IDAHO DEPARTMENT OF
HEALTH & WELFARE

Application for CHIP-B/Access Card

- **Available in Spanish.**
- **We provide interpreter services at no cost.**
- **Disponible en español.**
- **Proveemos servicios de interprete sin costo a usted.**
- **For application help, call 1-866-326-2485 or**

Instructions

IMPORTANT NOTICE: If you need any of the following kind of help, please ask. These services are free:

- **Language interpreter** (Interpreter services are available at no cost. Nosotros proveemos los servicios de un intérprete, sin costo alguno - call 1-866-326-2485 or Idaho CareLine, 1-800-926-2588);
- **Help in filling out this form;**
- **Form in alternate format** (Braille, large print, reader for the blind); or
- **Accommodations for a disability.**

This application is to be used when applying for the CHIP B and Children's Access Card programs. If you would like more information, go to www.idahohealth.org. To apply for CHIP B or Children's Access Card, follow these steps:

1. Complete the Application

- Answer all questions;
- If you apply for more than one child, you may give different answers for each child.

2. Provide Proof Requested

- On page 2, you are asked for a Social Security Number. If your child does not have one, go to the Social Security Office and apply for one. Send us a copy of the submitted application. Also, we can help you apply.
- We do not share Social Security Numbers with the federal immigration service.
- You have to give us citizenship and immigration information only for those who want benefits.

3. Mail the Application to:

Health and Welfare
CHIP Unit
150 Shoup Avenue, Suite 5
Idaho Falls, ID 83402-3653

4. How do I find out about my application?

Call 1-866-326-2485.

Equal Opportunity

In accordance with federal law and U.S. Department of Health and Human Services (HHS) policy, the Department of Health and Welfare is prohibited from discrimination on the basis of race, color, national origin, sex, age or disability. To file a complaint of discrimination, contact HHS, Office of Civil Rights, U.S. Department of Health and Human Services, Region X, 2201 Sixth Avenue, M/S RX-11, Seattle, WA 98121-1831, 800-368-1019 (voice) 800-537-7697 (TTY/TDD). HHS is an equal opportunity provider and employer.

What is your preferred language? Spoken _____ Written _____

Do you want an interpreter if you are interviewed? One will be provided at no cost to you. ☐Yes ☐No

Si usted es entrevistado, ¿quiere ayuda de un interprete? (Un interprete se le proveerá sin costo a usted.)
☐Sí ☐No

Case #: _____ ☐Received by Mail

Postmarked: _____

Assigned to: _____

Date Received: _____

Application for Assistance

Your First Name	Middle Initial	Last Name	Former Names, if any

Home Address	City	County	State	Zip Code

Mailing Address (if different)	City	County	State	Zip Code

Daytime Phone Number		If none, where can we leave a message?	E-Mail Address
	☐Work ☐Home	Phone:	

Follow these steps to choose your child's health plan:

1. Read the information below about CHIP B and the Children's Access Card programs.
2. Decide which program best fits your family.
3. Mark your choice on this form.
4. Return application and form in the envelope provided. If there is no envelope, mail to the address on page 2.

What is the difference between CHIP B and the Children's Access Card?

CHIP B: This is a state-managed individual health plan for **uninsured** children. The detailed benefit plan can be found at www.idahohealth.org. The cost of the CHIP-B Benefit Plan is $15 per month for each eligible child. You also may be responsible for co-pays on some services.

Children's Access Card: With the Children's Access Card, you can choose to join your employer-sponsored health plan or buy an individual health plan for your **uninsured** children. We will pay towards the cost of your monthly premium payments up to $100 per month for each eligible child, limited to $300 per family per month. You are responsible for the remaining premium payments, co-pays and deductibles of this plan.

List your child's name, then choose CHIP B **or** Children's Access Card for each child.

Child's Name	CHIP B	Children's Access Card
_____	☐	☐
_____	☐	☐
_____	☐	☐
_____	☐	☐
_____	☐	☐

If you are applying for the Children's Access Card, do you want CHIP B insurance coverage until your private insurance begins? ☐ Yes ☐ No

If your income is below the income level for these programs, would you like us to determine if you are eligible for Medicaid? ☐ Yes ☐ No

To make sure you receive all the help you qualify for, answer these questions by checking yes or no and listing who:

		Who?
Does anyone in your household have a disability?	☐Yes ☐No	_____
Is anyone in your household applying for or receiving Social Security?	☐Yes ☐No	_____
Do any children in your home have a parent **not** living with them?	☐Yes ☐No	_____

Name of parent not in the home: _____

Please list each person who lives in your home. Complete the information on this side of the line for each one. Include unborn children and due date.

Answer the questions on this side only for people requesting benefits. Any Social Security or immigration information on this application is private and will be used only for deciding eligibility.

NAME (First, Middle, Last)	**RELATION** (spouse, child, stepchild)	**DATE OF BIRTH**	**SEX**	**PREGNANT?** (✔ if yes)	**OTHER HEALTH INSURANCE OR MEDICAID?**	**PLEASE COMPLETE THE APPROPRIATE INFORMATION**
	Self		☐M ☐F		☐Yes ☐No	Social Security #____ U.S. Citizen: ☐Yes ☐No Alien ID# ____
			☐M ☐F		☐Yes ☐No	Social Security #____ U.S. Citizen: ☐Yes ☐No Alien ID# ____
			☐M ☐F		☐Yes ☐No	Social Security #____ U.S. Citizen: ☐Yes ☐No Alien ID# ____
			☐M ☐F		☐Yes ☐No	Social Security #____ U.S. Citizen: ☐Yes ☐No Alien ID# ____
			☐M ☐F		☐Yes ☐No	Social Security #____ U.S. Citizen: ☐Yes ☐No Alien ID# ____
			☐M ☐F		☐Yes ☐No	Social Security #____ U.S. Citizen: ☐Yes ☐No Alien ID# ____
			☐M ☐F		☐Yes ☐No	Social Security #____ U.S. Citizen: ☐Yes ☐No Alien ID# ____

If anyone in your family dropped health insurance in the past six months, list who and the reason dropped: ________________________

Are any family members employed by the State of Idaho? ☐Yes ☐No If yes, who? ____________________ Could children be covered by state insurance? ☐Yes ☐No

Please list all money received and/or expected by all household members for this month. If no one in your household receives money, check this box. ☐

TYPES OF MONEY RECEIVED (Wages, Social Security, Child Support, Unemployment, etc.)	**NAME OF EMPLOYER**	**HOW OFTEN PAID** (Weekly, Monthly, etc.)	**GROSS AMOUNT OF EACH CHECK** (Before Taxes or Deductions)	**WHO EARNED/RECEIVED MONEY**
		☐Weekly ☐Bi-weekly ☐Semi-monthly ☐Monthly ☐Annually		
		☐Weekly ☐Bi-weekly ☐Semi-monthly ☐Monthly ☐Annually		
		☐Weekly ☐Bi-weekly ☐Semi-monthly ☐Monthly ☐Annually		

Ethnicity and Race Information

Completion of this section of the Application for Assistance (AFA) is voluntary. Your selection of race and ethnicity will not affect your eligibility for benefits. This information is being collected to assure that program benefits are distributed without regard to race, color, or national origin. For the purposes of this section, “Hispanic or Latino” is considered an ethnicity, not a race. **Please answer both ethnicity and race questions for each person.**

Name (First, Middle, Last)	Ethnicity (✓ option that best describes each person)	Race (✓ one or more options that best describe each person)	Ethnicity and Race Definitions
	☐Hispanic or Latino ☐Not Hispanic or Latino	☐American Indian or Alaska Native ☐Asian ☐Black or African American ☐Native Hawaiian or Pacific Islander ☐White	**Ethnicity Definition** **Hispanic or Latino:** A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. **Race Categories Definitions** **American Indian or Alaska Native:** A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment. **Asian:** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam **Black or African American** A person having origins in any of the black racial groups of Africa. **Native Hawaiian or Pacific Islander** A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. **White** A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.
	☐Hispanic or Latino ☐Not Hispanic or Latino	☐American Indian or Alaska Native ☐Asian ☐Black or African American ☐Native Hawaiian or Pacific Islander ☐White	
	☐Hispanic or Latino ☐Not Hispanic or Latino	☐American Indian or Alaska Native ☐Asian ☐Black or African American ☐Native Hawaiian or Pacific Islander ☐White	
	☐Hispanic or Latino ☐Not Hispanic or Latino	☐American Indian or Alaska Native ☐Asian ☐Black or African American ☐Native Hawaiian or Pacific Islander ☐White	
	☐Hispanic or Latino ☐Not Hispanic or Latino	☐American Indian or Alaska Native ☐Asian ☐Black or African American ☐Native Hawaiian or Pacific Islander ☐White	
	☐Hispanic or Latino ☐Not Hispanic or Latino	☐American Indian or Alaska Native ☐Asian ☐Black or African American ☐Native Hawaiian or Pacific Islander ☐White	

Please tell us the following information:

1. Does anyone applying for health coverage need help paying medical bills from the last three months? ☐Yes ☐No
   If yes, who? _____. List gross amount (before taxes) received by your family in the last three months.

Last Month	Two Months Ago	Three Months Ago

2. As of today, how much does your household/family (including children) have in (list details on back):

Cash	Checking	Savings	Other Accounts/Trusts

3. List the year, make, model, and value of each car, truck or motorcycle your household owns. List others on back.

Year/Make/Model	Value	Amount You Owe	Year/Make/Model	Value	Amount You Owe

4. What is the **total value** of other assets such as land, trailers, boats, snowmobiles, other recreational vehicles? **(Do not include the home where you live.)**

Item	Value
_____	$ _____
_____	$ _____
_____	$ _____
_____	$ _____
_____	$ _____
_____	$ _____

I understand that . . .

- **Knowingly providing false information or withholding information may result in criminal, civil or administrative action (including denial of benefits or required repayment of benefits).**
- **My signature (or the signature of my representative) authorizes State and federal officials to get and use computerized and other information about me to determine if I am eligible for benefits.**
- **I may request a fair hearing if I disagree with decisions made regarding this application, and I have 30 days to do so.**
- **I must turn over any medical reimbursement payments I receive while I am enrolled in State health coverage to the Department of Health and Welfare.**
- **By applying for health coverage, child support services may pursue medical support and/or a child support order.**
- **My signature below certifies that the citizenship/immigration status marked on page 2 is correct for each person applying.**
- **My signature or the signature of my representative authorizes state officials to communicate with insurance companies related to my medical assistance.**

I, _____, swear that the information given on this form is true and correct.

_____

Signature of Applicant/Authorized Representative **Date**